REPORT TO THE TWENTY-THIRD LEGISLATURE
STATE OF HAWAI‘I
2006

PURSUANT TO HOUSE CONCURRENT RESOLUTION 40 HOUSE DRAFT 1 REQUESTING THE HAWAI‘I STATE COUNCIL ON DEVELOPMENTAL DISABILITIES TO CONTINUE TO CONVENE THE RESIDENTIAL SETTINGS TASK FORCE TO IDENTIFY ISSUES AND SOLUTIONS REGARDING INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES AND THEIR CHOICE OF RESIDENTIAL SETTING

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INTRODUCTION

The Twenty-Second Legislature in 2004 adopted Senate Concurrent Resolution 79 Senate Draft 1 House Draft 1 requesting the Hawai‘i State Council on Developmental Disabilities (Council) to convene a task force to identify issues and solutions regarding individuals with developmental disabilities and their choice of residential setting. The Council convened the Residential Settings Task Force (Task Force) and conducted meetings to address Senate Concurrent Resolution 79 Senate Draft 1 House Draft 1.

The Task Force completed an initial report that described the residential options currently available for individuals with developmental disabilities and the statutes, administrative rules, policies, and directives that impact residential settings for those individuals. While the Task Force identified significant issues that surround and impact individual choice and self-determination, and recognized the complexity of issues, the Task Force was not able to complete all the analysis. It was agreed that further analysis was necessary to fully address the scope of increasing residential options for persons with developmental disabilities including residency in settings that do not require licensure.

The Task Force agreed to continue its work, including the further analysis of statutes, administrative rules, policies, and directives, and to continue to discuss and outline the details of recommendations that were not included in the report.

The 2005 Legislature adopted House Concurrent Resolution 40 House Draft 1 requesting the Hawai‘i State Council on Developmental Disabilities to continue to convene a task force to identify issues and solutions regarding individuals with developmental disabilities and their choice of residential setting.

During the last few years, there has been a shift in residential options including a significant decrease in developmental disabilities domiciliary homes. Funding for residential services across the board for all residential services providers has not kept pace with the growing need to provide increased options for persons with developmental disabilities. Consequently, seven developmental disabilities domiciliary homes discontinued their provision of services in recent years. With the closure of these homes came the loss of U. S. Department of Housing and Urban Development contracts that provided subsidy payments to the provider or to the individual living in that home, resulting in substantially less federal funds for the State of Hawaii to leverage for these services. The task before us is clear: working in partnership with our state and federal governments and private sector providers, we must create opportunities that encourage the opening of more developmental disabilities domiciliary homes and support an appropriate level of funding for the operators of these community-based settings.

To help address this urgent situation, the 2005 Legislature passed and the Governor signed into law legislation to ensure that developmental disabilities residential service providers are adequately reimbursed for services. Act 168, SLH 2005, gave the Department of Health authority to enter into contracts for additional payments for residential services to the providers of developmental disabilities domiciliary homes and

payments to operators of developmental disabilities apartment complexes for residential services on terms determined by the Department of Health. Act 236, SLH 2005, provides funding to implement Act 168.

The State has recognized that there is a housing crisis for people of Hawai‘i with and without disabilities. The high cost of living, limited housing options for the general population, and aging family caregivers have contributed to the challenge to provide affordable and available housing.

Based on the census from the Department of Health, Developmental Disabilities Division approximately sixty (60) percent of individuals with developmental disabilities live with their families. As family caregivers become older and are not able to care for their family member with developmental disabilities, other residential options will be pursued and considered. The Administration has acknowledged the urgency to address the need to increase residential options for this population may result in unintended consequences such as continued loss of financial resources, decrease in provider capacity, closures of developmental disabilities domiciliary homes, displacement of individuals, and litigation on behalf of individuals with developmental disabilities.

PURPOSE

The purpose of House Concurrent Resolution 40 House Draft 1 is to request that the Hawai‘i State Council on Developmental Disabilities (Council) continue to convene a task force to identify issues and solutions regarding individuals with developmental disabilities and their choice of residential setting.

OUTLINE OF ACTIVITIES

The Task Force was to continue its review and analysis of increasing residential options, including residency in homes that do not require a license; statutes, administrative rules, policies, and directives; and recommendations that were not included in the initial report.

The Task Force outlined its activities to address the following:

(1) Identify residential options available;
(2) Address individual choice and self-determination in increasing residential options, including exploring settings that don’t require licensure;
(3) Identify statutes, administrative rules, policies, and directives that if revised would allow settings that do not require licensure, however would be able to provide safe and healthy environments, as a residential option;
(4) Identify statutes, administrative rules, policies, and directives that need to be revised to reflect individual choice and assure civil rights, health, and safety; and
(5) Coordinate its activities with the Olmstead Task Force to prevent duplication of work.

The Task Force continued to include representatives from the following agencies, organizations, or affiliations that the initial Senate Concurrent Resolution 79 Senate Draft 1 House Draft 1 called for:

(1) Individuals with developmental disabilities
(2) Family members of individuals with developmental disabilities
(3) Department of Health, Developmental Disabilities Division
(4) Department of Health, Office of Health Care Assurance
(5) Department of Health, Adult Mental Health Division
(6) Department of Health, Hawai‘i State Council on Developmental Disabilities
(7) Department of Human Services, Social Services Division
(8) Hawai‘i Disability Rights Center
(9) Office of the Public Guardian
(10) Residential services providers such as operators of adult residential care homes, developmental disabilities domiciliary care homes, and adult foster homes
(11) Support services providers

The Task Force was requested to submit a follow-up report, including any proposed legislation, to the Legislature no later than twenty (20) days prior to the convening of the Regular Session of 2006.

Certified copies of House Concurrent Resolution 40 House Draft 1 were transmitted to the Chair and Executive Administrator of the Hawai‘i State Council on Developmental Disabilities, Director of Health, Director of Human Services, President of the Hawai‘i Disability Rights Center, and Director of the Office of the Public Guardian.

I. RESIDENTIAL OPTIONS AVAILABLE

A review of residential settings available was completed in the Senate Concurrent Resolution 79 Senate Draft 1 House Draft 1 initial report (December 2004). This review provided citations of the applicable Hawai‘i Revised Statutes and Hawaii Administrative Rules for the various residential settings for persons with developmental disabilities.

A. Summary of Residential Settings for Persons with Developmental Disabilities

Appendix B provides an updated summary of current licensed/certified residential settings available for persons with developmental disabilities. The information includes:

(1) Type of Residence
(2) Hawai‘i Administrative Rules/Hawai‘i Revised Statutes
(3) License/Certification
(4) Funding
(5) Payment Amount Monthly
(6) Number of Unit
(7) Capacity
(8) Number of Pending Applicants
(9) Maximum Number of People Per Unit
(10) Current Residents
(11) Persons Eligible
(12) Services
(13) Comments

All but one residential setting is licensed/certified by the Department of Health. The Residential Alternatives Community Care Program homes are certified by the Department of Human Services.

Payments for the residential settings listed in the summary are primarily funded by state and/or federal sources with the exception of assisted living facilities. The Department of Human Services currently has a contract with one assisted living facility to accept the Residential Alternatives Community Care Program payment for clients accepted into that facility. This is the only assisted living facility that receives any state/federal funding.

The following is a summary relating to Appendix B of adult residential settings for person with developmental disabilities:

1. Adult foster home means a private home providing care on a twenty-four (24) hour basis for adults with developmental disabilities. To be certified, an adult foster home shall have not more than two (2) adults with developmental disabilities at the same time, who are unrelated to the foster family. To accommodate residents of a foster boarding home for children with developmental disabilities who reach the age of eighteen (18) years, where the home is certified as a foster boarding home for children, the Director of Health

may waive the two (2) adult limit for certification of that home as an adult foster home, provided that:

(1) The number of foster children and adults in such a dually certified home shall not exceed five (5), and

(2) No new adults may be admitted into the home while there are any foster children residing in the home. The Department of Health is authorized to certify adult foster homes for individuals with developmental disabilities requiring such care beyond the eighteenth birthday.

2. Adult residential care home means any facility providing twenty-four (24) hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, but who do not need the services of an intermediate care facility. It does not include facilities operated by the federal government. There shall be two (2) types of adult residential care homes:

(1) Type I - for five (5) or less residents. Type I adult residential care homes are usually single-family dwellings operated by a family, however, there are homes owned and operated by companies/corporations; and

(2) Type II - for six (6) or more residents. Type II adult residential care homes have a number that are single-family dwellings with eight (8) residents. The larger Type II homes are similar to nursing homes in structure, however, do not need to meet all of the building and fire requirements as required for nursing homes.

3. Expanded adult residential care home means a category of an adult residential care home qualified to serve nursing home level residents. There shall be two (2) types of expanded adult residential care homes:

(1) Type I home shall consist or five (5) or less residents with no more than two (2) nursing home level residents; and

(2) Type II home shall consist of six (6) or more residents with no more than twenty (20) percent of the home's licensed capacity as nursing facility-level residents.

4. Assisted living facility means an assisted living facility as defined by State statute. This facility shall consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The environment of an assisted living facility shall include one in which meals are provided, staff are available on a twenty-four (24) hour basis, and services are based on the individual needs of each resident. Each resident, family member, and significant others shall work together with the facility staff to assess what is needed to support the resident so that the resident can achieve his or her greatest capacity for living independently. The facility shall be designed to maximize independence and self-esteem of limited mobility persons who feel that they are no longer able to live on their own.

5. Developmental disabilities domiciliary home means any facility licensed to provide twenty-four (24) hour supervision or care, excluding licensed nursing care, for a fee, to not more than five (5) adults with mental retardation or developmental disabilities.

6. Intermediate care facility for the mentally retarded means an identifiable unit providing residence and care for fifteen (15) or less individuals with mental retardation. Its primary purpose is the provision of health, social, and rehabilitative services to individuals with mental retardation through an individually designed active treatment program for each resident. No person who is predominantly confined to a bed shall be admitted as a resident.

7. The Residential Alternatives Community Care Program is a Medicaid waiver program for adults who because of significant medical and functional needs can no longer live in their own home choose to live in a community-based home as an alternative to placement in an intermediate care facility/skilled nursing facility.

8. Semi-independent - Individuals may live in agency-operated apartments that are not licensed, but regulated by the United States Department of Housing and Urban Development. Minimal supervision is provided on-site by agency staff.

   According to Stancliffe and Whaite (1997) and Van Dam, and Cameron-McGill (1995), the definition for semi-independent living "is for individuals with the mildest disabilities who can succeed with low levels of paid staff support (10-20 hours a week)."

9. Therapeutic living program means a supervised living arrangement that provides mental health or substance abuse services for individuals or families who do not need the structure of a special treatment facility and are transitioning from a more restrictive treatment setting to independent living. The program aids residents in meeting basic needs and provides supportive services through a required service plan.

10. Special treatment facility means a facility that provides a therapeutic residential program for care, diagnoses, treatment, or rehabilitation services for persons with social or emotional distress, persons with mental illness, persons affected by substance abuse, and people with developmental disabilities. Facilities provide care and/or services to adults as well as youth.

11. Family - Individual resides in his/her family's home with no requirements or regulations for licensure.

12. Independent – People living independently are not subject to the control or influence of another person. Individuals may live independently:
    (1) in their parents home
    (2) in an apartment which they are renting

(3) in a group living situation
   a. allowed by the City and County zoning code for five (5) unrelated individuals; and
   b. a rental agreement is in place.

B. Summary of Adult Mental Health Division's Residential Treatment Settings and Community Housing Program for Persons with Severe and Persistent Mental Illness

Appendix C provides a summary of Adult Mental Health Division's Residential Treatment Settings and Community Housing Program for persons with severe and persistent mental illness. As noted in the summary, payments for the licensed residential treatment settings are paid by through the Medicaid Rehabilitation Option at a daily unit rate. The Adult Mental Health Division's Community Housing Program is not required to be licensed, consumers have the rights of tenancy, and is paid at a unit rate for twenty-four (24) hour and eight to sixteen (8-16) hour group homes, and cost reimbursement for semi-independent housing and the Supported Housing Program. Monthly payments for similar residential services (e.g. twenty-four (24) hour group home and eight to sixteen (8-16) hour group homes and apartments) are significantly greater than payments for individuals with developmental disabilities residing in developmental disabilities domiciliary homes and semi-independent apartments.

The description of settings is noted in this report because the Task Force recognizes that people with mental illness can have mental illness and developmental disabilities. The information includes:

(1) Type of Service
(2) License or Certification
(3) Funding Type-Agency
(4) Daily Bed Rate Amount*
(5) Bed Capacity (in accordance with county zoning requirements)

* Note that a daily bed rate is calculated rather than a monthly rate as is calculated for persons with developmental disabilities. A daily bed rate is used because individuals may not stay in the residential setting for the full month.

For individuals with serious mental illness, the impetus for providing adequate funding for mental health residential options was a consent decree under the United States Department of Justice to move people out of the Hawai‘i State Hospital into the community. A housing plan was developed and, through the compassion and support of the State Legislature, funds were appropriated to increase residential options for people with serious mental illness.

Because the Department of Health, Adult Mental Health Division's residential settings are adequately funded, residential options for individuals with mental illness are

increasing. Individuals with mental illness and developmental disabilities may qualify for these resources. Future discussion is needed with the Department of Health, Adult Mental Health Division to explore alternatives for people with co-occurring diagnoses (mental illness and developmental disabilities) and to support individuals with developmental disabilities and mental illness to choose residential options from either the Department of Health's Developmental Disabilities Division or Adult Mental Health Division.

The following is a summary relating to Appendix C of the Adult Mental Health Division's Residential Treatment Settings and Community Housing Program for persons with severe and persistent mental illness:

Licensed Residential Treatment Programs

1. Specialized Residential Treatment Services:
   The provider shall provide specialized residential services to adults with severe and persistent mental illness ("consumers") on the island of O'ahu. This level of service shall be directed to consumers who are being discharged from the Hawai'i State Hospital, consumers who, without twenty-four (24) hour care, would further de-compensate and increase their likelihood of hospitalization, or those consumers whose goal is to move into more independent living options from a higher level of care. This service is also designed for consumers who have co-morbid medical conditions, including physical disabilities, who have suffered the effects of institutionalization in long-term psychiatric hospitals, and who may require unique and highly specialized services that do not typically exist in the community. These consumers often exhibit socially inappropriate and bizarre behaviors that may be very challenging to treatment providers and as a result severely limit placement options in the community. Due to the severity of their co-morbid medical conditions, these consumers may require very close or constant supervision and/or ongoing prompting.

   The specialized residential service is a facility-based, non-hospital, or nursing facility program for consumers, and is designed to be individualized, integrated into the community, consistent with the consumers' needs, and provided in the least restrictive setting as possible. Services shall be provided by staff on-site and on-duty, twenty-four (24) hours per day, seven (7) days per week. The goal of specialized residential services is to increase each consumer's functioning so that she/he may eventually live successfully in the residential setting of her/his choice and to decrease the frequency and duration of hospitalization. Supports provided to consumers shall be flexible, focused on recovery, linked, and planned with full consumer involvement.

2. Specialized Residential Treatment Services for Dual Diagnosis
   This service provides twenty-four (24) hour per day non-medical, non-acute care in a residential treatment facility. It includes a planned regimen of professionally directed evaluation, treatment, rehabilitation, medication management and other

ancillary and special services. Observation, monitoring and treatment are available twenty-four (24) hours a day, seven (7) days a week. Services are comprehensive and all inclusive to aid in developing daily living skills, which enable consumers to manage symptoms and regain functioning lost due to mental illness and substance abuse (also referred to as co-occurring or dual diagnosis). Individual and group activities and programming shall include services to restore and develop skills in functional areas which interfere with each consumer's ability to live in the community, to live independently, regain or maintain competitive employment, to develop or maintain social relationships, or to independently participate in social, interpersonal, community and peer support activities to increase community stability.

3. Interim Housing:
Interim Housing provides integrated treatment based upon helping people build new and more effective behavioral strategies that contribute to fitness restoration and achieving their personal recovery goals. Wellness Recovery Action Planning is used to assist consumers in developing improved behavioral responses that manage risk, promote recovery and prevent relapse (defined as loss of skill and functioning) and facilitate personal responsibility for actions. Social skills, self-monitoring and emotional regulation skills assist consumers in developing a more stable lifestyle and are less focused on eliminating maladaptive behaviors. The structured setting focuses on lifestyle changes that pay attention to contextual factors or triggers that contribute to relapse, and those factors that serve to maintain behaviors that are counter-productive to personal recovery goals. For example substance usage and any violation of conditions under the conditional release may contribute to hospitalization or arrest and job loss. Length of stay is up to six months. The program is a Medicaid Rehabilitation Option service and required to be licensed by the Department of Health, Office of Health Care Assurance.

Adult Mental Health Division Community Housing Program (Certified):

4. Twenty-four (24) Hour Group Homes:
This service is directed to consumers being discharged from the Hawai‘i State Hospital and to those consumers who without twenty-four (24) hour care, would further de-compensate and increase their likelihood of hospitalization. The expected length of stay in this program is up to six (6) months. Consumers have the rights of tenancy. Services include, but are not limited to, housing assessments; development and implementation of a housing plan; encourage coordination and linkage to activities in the community, including, clubhouses, psychosocial rehabilitation programs, jobs, etc.; social and recreational activities during the days, evenings and weekends; and cooperatively and collaboratively working with individuals providing "wrap" services to consumers residing in the home. The staff on site provides consumers "in-vivo" life skills training including, but not limited to cooking, household chores, shopping, transportation,

and money management. Consumers are encouraged to share the responsibility for the daily upkeep of the group home or apartment.

5. Eight to Sixteen (8-16) Hour Group Homes:
The eight to sixteen (8-16) hour group home offers group living with support staff on-site between eight (8) to sixteen (16) hours per day, seven (7) days per week. Pre-authorized "wrap" services, as authorized by the Adult Mental Health Division's Utilization Management process, are available to consumers who require this service. The supportive staff on site provides consumers "in vivo" life skills training including but not limited to cooking, shopping, transportation, and money management. Consumers have the rights of tenancy and are encouraged to share the responsibility for the daily upkeep of the group home or apartment.

The eight to sixteen (8-16) hour group home services are similar to that of the twenty-four (24) hour group home, except the services are provided within an eight to sixteen (8-16) hour day period based on the needs of the consumers in the home. The expected length of stay is up to two (2) years. The Adult Mental Health Division's utilization management process regularly assesses consumers to determine if earlier transition to a more independent living arrangement is appropriate.

6. Semi-Independent Living:
The Semi-Independent Living offers group living with property management staff on site eight (8) hours per day. Weekend staff coverage, is based on the needs of the consumers residing in the home. Pre-authorized "wrap" services are available to consumers who require this service. The supportive staff on site provides consumers "in vivo" life skills training including but not limited to cooking, shopping, transportation, and money management. Consumers are encouraged to share the responsibility for the daily upkeep of the group home or apartment.

There is no maximum length of stay in this level of housing and consumers have the rights of tenancy. Adult Mental Health Division's utilization management program regularly assesses consumers to determine if transition to a more independent living arrangement is appropriate.

7. Supported Housing Program:
The Supported Housing Program provides housing for persons who are stabilized and can live in the community with appropriate supports. The program is based upon a threefold commitment: 1) The client selects housing of his/her choice (rentals in the community) and assumes the responsibilities of tenancy; 2) A twenty-four (24) hour flexible and responsive support team provides visits to both tenant and landlord to assure the consumer maintains independence in the community; 3) A temporary rental subsidy is provided to make housing affordable for the consumer. The rise of supported housing developed out of the need for stability, which was often compromised by the residential continuum of

care in which a consumer was gradually assimilated into the community through graduation to more independent, normalized settings.

8. Shelter-Plus Care:
The Shelter-Plus Care Program is a United States Department of Housing and Urban Development funded program awarded to Steadfast Housing Development Corporation and Catholic Social Ministries for homeless persons with severe and persistent mental illness. The Adult Mental Health Division, in partnership with these agencies, provides the service match for these homeless consumers placed in housing. The program is based upon a threefold commitment: 1) The homeless client selects housing of his/her choice (rentals in the community) and assumes the responsibilities of tenancy; 2) A twenty-four (24) hour flexible and responsive support team provides visits to both tenant and landlord to assure the consumer maintains independence in the community; 3) A United States Department of Housing and Urban Development rental subsidy is provided to make housing affordable for the consumer.

II. INVENTORY OF RESIDENTIAL OPTIONS

An inventory of residential options was included in the Senate Concurrent Resolution 79 Senate Draft 1 House Draft 1 initial report (December 2004). The following information provides an update of:

1. The number of developmental disabilities domiciliary homes and adult foster homes.
2. The settings in which people with developmental disabilities live by county. See Table 1.
3. Developmental disabilities domiciliary homes in Hawaii. See Table 2.
4. The trend for developmental disabilities domiciliary homes and adult foster homes. See Table 3.
5. The types and number of residential settings licensed by the Department of Health, Office of Health Care Assurance. See Table 4.

A. Developmental Disabilities Domiciliary Homes and Adult Foster Homes

The Department of Health licenses and/or certifies two (2) types of residential settings:
(1) Developmental disabilities domiciliary homes; and
(2) Adult foster homes for individuals with developmental disabilities.

Both types of homes must meet:
(1) City and County building codes;
(2) Character checks including a criminal history record clearance; and
(3) Financial viability.

These homes are responsible to provide twenty-four (24) hour care and supervision. Any complaints or allegations of abuse, neglect, or exploitation are investigated by the Department of Health staff in coordination with the Department of Human Services, Adult Protective Services.

<u>Developmental Disabilities Domiciliary Homes and Adult Foster Homes</u>

- Number of individuals residing in above homes: 640 (represents twenty (20) percent of individuals known to the Department of Health).
- Homes are initially licensed/certified and inspected on an annual basis by the Department of Health, Office of Health Care Assurance.
- Payments for the above residential settings are paid through State Supplemental Payments (a combination of federal and state dollars) for "individuals living in domiciliary care". Payment of $1,124.90* per month per individual residing in the home, of which $30.00 is the resident's monthly allowance.
- Additional services needed by the individual may be obtained through the Medicaid Home and Community-Based Services Waiver program.

* This is the rate effective January 1, 2006 *(Source: Department of Human Services, Social Services Division, December 2005).*

DD Domiciliary Homes (As of November 23, 2005)

- Number of licensed homes: 32
  - Agency operated homes: 17
  - Family-operated homes: 15
- Number of individuals residing in homes: 119
- Maximum number of individuals per home: Up to five (5) individuals

Adult Foster Homes

- Number of certified homes: 286
- Number of individuals residing in homes: 486
- Maximum number of individuals per home: Up to two (2) individuals

(Source: Department of Health, Developmental Disabilities Division and Office of Health Care Assurance, November 2005.)

Table 1 describes the settings in which people with developmental disabilities live by county.

Of the residential settings listed, sixty-five (65) percent of individuals with developmental disabilities receiving services from the Developmental Disabilities Division live with their families followed by fifteen (15) percent living in adult foster homes, five (5) percent living in adult residential care homes, four (4) percent living in developmental disabilities domiciliary homes, and three (3) percent live alone.

TABLE 1

Settings in Which People With Developmental Disabilities Live by County

Type of Setting	Hawaii	Kauai	Maui	Oahu	Total (1)
Adult Foster Home	11	16	22	437	486
Alone	36	13	6	56	111
Assisted Living	0	0	0	7	7
Care Home 1 (1-5)	15	10	1	156	182
Care Home 2 (6+)	0	2	0	5	7
Child Foster Home	11	1	4	21	37
DD Dom Home	5	0	6	134	145
Ext. Care Home (ARC)	1	1	4	50	56
Hospital	3	1	1	5	10
ICF-MR-C (2)	0	0	0	3	3
Institution	0	0	0	8	8
Nursing Facility	0	4	1	8	13
Other	6	0	4	49	59
Family	345	149	166	1,499	2,159
With Other	6	4	4	29	43
No Entry	46	14	17	105	182
Total	469	209	234	2,447	3,347

(1) Total figures are duplicate counts if person moved during the year
Total of 3,347 is an unduplicated figure
(2) People are receiving services from the Developmental
Disabilities Division
(3) "With Other" includes persons living with people other than their families

(Source: Department of Health, Developmental Disabilities Division, December 2005.)

Table 2 provides a list of developmental disabilities domiciliary homes operated by private service providers and families.

Table 2 represents the number of developmental disabilities domiciliary homes operated by private provider agencies and families. As the table shows, there are five (5) private providers (The Arc in Hawaii, ORI-Opportunities for the Retarded, and RCH – Responsive Caregivers of Hawaii, Kona Krafts and The Arc of Maui) that operate developmental disabilities domiciliary homes. Agency operated homes comprise fifty-three (53) percent of the developmental disabilities domiciliary homes (17 total) and family operated homes comprise forty-seven (47) percent of those homes (15 total). During the past year, one (1) family operated home closed on Maui, however, there was a slight increase from twenty-six (26) to thirty (30) family operated homes statewide. No increases represented for agency operated homes.

TABLE 2

List of Developmental Disabilities Domiciliary Homes in Hawai‘i
As of November 23, 2005

	Oahu	Hawaii	Maui	Kauai	Total
Agency Operated	**10- (Arc)** **2- (ORI)** **3- (RCH)**	**1- (Kona Krafts)**	**1- (Arc of Maui)**	**0**	**17**
Family Operated	**15**	**0**	**0**	**0**	**15**
Total	**30**	**1**	**1**	**0**	**32**

(Source: Department of Health, Developmental Disabilities Division, November 2005.)

Table 3 provides information on the trends in adult foster and developmental domiciliary homes for the period 2001-2005.

Table 3 represents the number of adult foster and developmental disabilities domiciliary homes during 2001- 2005. During the last five years, there has been a shift in the number of adult foster homes and developmental disabilities domiciliary homes. In 2001, there were two hundred and sixty (260) adult foster homes and in 2005, there are two hundred and eighty-eight (288) homes. For developmental disabilities domiciliary homes, there has been a decrease of homes from forty-three (43) to thirty-two (32) homes. The decrease reflects the closure of eleven (11) homes over the five (5) year period.

TABLE 3

Trends in Adult Foster and Developmental Disabilities Domiciliary Homes 2001-2005

	2001	2002	2003	2004	2005
Number of Adult Foster Homes	260	268	269	275	288
Number of Developmental Disabilities Domiciliary Homes	43	40	41	36	32
Total Number of Homes	303	308	310	311	320

(Source: Department of Health, Developmental Disabilities Division, December 2005.)

TABLE 4

Office of Health Care Assurance Licensed Residential Settings
November 18, 2005

Adult Residential Care Home (ARCH) includes Type I, Type II and Expanded Care
Total # in State = 494
Total resident capacity = 2608

Breakdown by Island:

	# of ARCHs	Capacity	# of ECARCHs	Capacity
Maui	13	61	1	2
Hawai‘i	48	211	14	28
Kaua‘i	16	73	1	2
Moloka‘i	4	31	1	3
O‘ahu	413	2232	160	347
TOTAL	494	2608	177	382

Current/pending ARCH applications = 44

Special Treatment Facilities (STF)
Total # in State = 38
Total Resident Capacity = 701

	# of STFs	Capacity
Maui	4	75
Hawai‘i	4	49
O‘ahu	30	577
TOTAL	38	701

Current/pending STF applications = 0

Therapeutic Living Programs (TLP)
Total # in State = 15
Total Resident Capacity = 107

	# of TLPs	Capacity
Maui	2	23
Hawai‘i	2	12
Kaua‘i	2	12
O‘ahu	9	60
TOTAL	15	107

Current/pending TLP applications = 1

Developmental Disabilities Domiciliary Homes (DDDH)
Total # in State = 32 State = 32
Total Resident Capacity = 130

	# of DDDHs	Capacity
Maui	1	5
Hawai‘i	1	5
O‘ahu	30	133
TOTAL	32	143

Current/pending DDDH applications = 2

Assisted Living Facilities (ALF)
Total # in State = 10
Total Resident Capacity = 1744

	#of ALFs	Capacity
Maui	1	144
Hawai‘i	1	220
Kaua‘i	1	100
O‘ahu	7	1280
TOTAL	10	1744

Current/pending ALF applications = 0

(Source: Department of Health Office of Health Care Assurance, Licensing Section, November 18, 2005.)

III. ADDRESS INDIVIDUAL CHOICE AND SELF-DETERMINATION IN INCREASING RESIDENTIAL OPTIONS, INCLUDING EXPLORING SETTINGS THAT DON'T REQUIRE LICENSURE

There were numerous issues addressed by the Task Force that relate to increasing residential options while maintaining health and safety standards, and providing more consumer-control and consumer-directed services and supports. It was recognized that not all issues could be adequately addressed given the time constraints. Therefore, the Task Force identified the following five priority areas to be addressed:

A. Aging Population
B. Crisis Network Services
C. Financial
D. General
E. Licensure and Regulations

Issues were identified for the above priority areas and recommendations were determined for further action and follow-up.

A. Aging Population

Aging in place has become an issue especially for the aging population. It is a lifelong issue and not just an aging issue. Ideally, aging in place is the ability for the elderly to live in a setting of their choice for as long as possible, with the necessary support services. The purpose of aging in place is for people to be able to remain in their homes regardless of a change in their medical, social, psychological, and other conditions. Individuals who are aging in place should have the support to continue in their residential setting even though their physical and mental capacities have decreased or diminished. An individual should not be required to move from one's present residence in order to secure necessary support services in response to changing need.

The Task Force summarized and prioritized the following issues relating to the issue of aging:

1. Transfer Trauma
2. Financial Reimbursement
3. Health and Safety Monitoring
4. Training for Caregivers

1. Transfer Trauma

This issue was identified as a major issue to address. Different residential settings have different state and federal requirements that impact on allowing a person to age in place in his/her residence.

Issues:

a. The determination of the intermediate care facility for the mentally retarded level of care is based on the active treatment needs of the individual. If there is no need for active treatment, and the medical needs far surpass the training needs, then it may be determined that the individual would need to look at different residential options. Providers of intermediate care facility for the mentally retarded facilities are paid a per diem rate per individual based on federal requirements.

b. For developmental disabilities domiciliary homes, issues are current statutory language indicating that residents requiring skilled nursing services would not be able to remain in the setting. There is need for comprehensive assessments to determine the specific needs of the residents as well as skilled and competent providers to meet the resident needs.

c. For adult residential care homes, issues are the need for skilled and competent providers that are able to meet the resident needs. Those operators that demonstrate competency and meet the requirements can choose to be licensed as expanded adult residential care homes.

d. Although administrative rules are in place for the above residential settings, waivers may be granted under certain conditions and circumstances when the health and safety of the residents can be assured and an effective system is in place.

e. Aging in place and end of life care were determined as issues to be addressed separately from each other. For end of life care, hospice services can be available in the home or setting (be it a licensed health care setting or the individual's own family home).

Current Initiatives:

a. The Department of Health has convened a work group of various providers and community agencies to address the issue of transfer trauma or relocation stress syndrome. In July 2004, Department of Health developed guidelines for case managers to use to mitigate the effects of relocation/transfer.

b. This work group is planning and coordinating a conference in early Spring 2006 for caregivers and professionals that may include a mainland consultant and local experts to increase awareness of factors contributing to relocation, identify specific factors in various situations, and design appropriate interventions where relocation stress occurs.

Recommendations:

a. Establish a peer counseling service that will provide a peer counselor to the individual who is moving to a different home to minimize trauma and to provide peer education and training related to transfer trauma to direct care staff.

b. Identify other groups to assist with providing peer-to-peer education and training relating to transfer trauma.

c. Developmental Disabilities Division to establish an education and training component on transfer trauma for individuals with developmental disabilities, families, and caregivers as part of quality assurance.

2. Financial Reimbursement

Financial reimbursements relating to aging in place is a growing concern. When individuals transfer from one residential setting to another, costs for the transfer may not be covered and providers may need to meet more stringent requirements depending on the individual's level of care. This also holds true for a provider who allows a person to remain in their home to age in place. If the provider is licensed as an adult residential care home and the person requires intermediate or skilled nursing care, the provider must obtain an expanded adult residential care home license to continue to care for the person.

Issues:

a. State and/or federal funding are needed to address the issue of aging in place.

b. Funding for training is needed.

c. Funding for additional services is needed to support individuals.

d. Double-dipping/reimbursement – The federal government may have initiated a program that allows for skilled nursing and hospice services to be provided at the same time using a lower rate of payment for hospice services. This relates to the intermediate care facility for individuals with mental retardation per diem rate payment issue.

e. Additional funding is needed to upgrade house/structure in some cases. Federal funding through the Americans with Disabilities Act and federal grants may be available to meet this need.

f. Funding is needed to cover liability costs.

g. Adult residential care homes can apply for low interest loans for upgrades/renovations through the City and County of Honolulu.

Recommendations:

a. Increase funding for training of caregivers.

b. Pursue other state and federal grant resources that may be available.

c. Identify how the state can assist providers to address liability costs.

d. Look at the City and County low cost loan program as a model to follow to offer something similar statewide for residential/community health care settings.

3. Health and Safety Monitoring

The Centers for Medicare and Medicaid Services require states to have standards and safeguards in place to assure health, safety, and welfare.

Issue:

a. The Department of Health does require nursing oversight when needed and must move the person when such nursing services cannot be provided where the person lives. The Department of Health may authorize nursing home level services depending on the residential setting and funding to assist with this issue.

Recommendations:

a. The Department of Health to review its rules and polices, and consider alternatives for an individual needing nursing care to support people aging in place and preventing transfer trauma.

b. The Department of Health to consider alternatives for an individual needing nursing care to remain in their current setting taking into consideration the individual's higher level of care needs, the skill and competency level of the provider and any structural requirements that may need to be made to accommodate the individual (i.e., bathroom, grab bars, handrails, etc.).

4. Training for Caregivers

Issues:

a. The Visions training curriculum for caregivers in developmental disabilities domiciliary homes needs to be updated.

b. There is a need for adequate medical personnel oversight for health monitoring and assessments.

c. All people working with the individual, not only the caregiver must be trained.

Current Initiatives:

a. The Department of Health, Office of Health Care Assurance, is currently reviewing the adult residential care home modules curriculum to meet standards of care and to ensure consistency statewide.

b. As part of the Governor's initiative on work force development, the Department of Health, in coordination with the state community colleges, took the lead in establishing a statewide certified nurse's aide training program that includes cultural sensitivity and awareness, behavioral management, ethical issues, and business management.

c. The Department of Health is also currently reviewing the Visions curriculum to determine areas that require updating and enhancement.

d. The Administration has a comprehensive Long-term Living Initiative that was established by Department of Health at the direction of the Governor to address the State's current and future long-term care needs. This Initiative includes:
   i. A Certified Nurse's Aide curriculum, apprenticeship program, and certification program.
   ii. A financial component to enact tax credits for the purchase of long-term care insurance. This component includes an initiative to educate employers and individuals regarding long-term care insurance.
   iii. An infrastructure component to assess Hawai'i's long-term care needs.

Recommendations:

a. The Department of Health to develop a training program available for direct support workers that will include an optional web-based training program, such as the College of Direct Support.

b. The Department of Health to develop a training plan in collaboration with providers that identifies needs for initial and ongoing education and training, and stakeholders to be included.

B. Crisis Network Services

Issue:

a. The need for a safety net of services and supports has been a priority in the community. Crisis prevention and intervention services are key components in the service delivery system to support individuals with developmental disabilities to live in the community and caregivers to maintain them in the home.

Current Initiatives:

a. The Department of Health, Developmental Disabilities Division issued a Request For Proposals for Crisis Network Services in November 2005.

Crisis Network Services will provide a prevention-based system of behavioral supports and services for individuals with challenging behaviors eligible for services under Hawai‘i Revised Statutes Chapter 333F, their families, caregivers, and providers. Crisis Network Services shall develop skills and expertise of stakeholders through training and consultation as well provide effective prevention-oriented supports. Crisis response services and temporary out-of-home residential services shall be provided if determined necessary.

A key activity to increase the capacity of the behavioral supports system will be to develop a Crisis Network. The Crisis Network will consist of representatives from service providers, families, and relevant state agencies. The Crisis Network shall be convened by the selected provider and the Department of Health, Developmental Disabilities Division on a regular basis to develop mutual support and build on collaborative efforts for a comprehensive, prevention-based and effective system of behavioral supports. The Provider will enhance the capacity of the Crisis Network by providing group training and separate consultation on individuals. Regular meetings of the Crisis Network will also provide input to the Provider on behavioral issues that impact on the delivery of Crisis Network Services.

To maximize state funding and provide a seamless statewide system of supports, Crisis Network Services shall be provided for all individuals in need using a combination of Developmental Disabilities/Mental Retardation Medicaid waiver and Purchase of Services (100% State) funding. If an individual is Medicaid eligible and admitted into the Developmental Disabilities/Mental Retardation Medicaid Waiver, the Provider shall bill the Developmental Disabilities/Mental Retardation Medicaid waiver for billable services. If an individual is not eligible for Medicaid or not admitted to the Medicaid waiver, funds under the contract shall be used for training and consultation, outreach, crisis shelter services and behavioral home services.

The goals of the Crisis Network Services are to: (1) develop and coordinate education/ training/prevention efforts to increase skills and expertise of those who support individuals with developmental disabilities/mental retardation with challenging behaviors; (2) provide means for families, caregivers, and providers to request and access immediate assistance for crisis outreach and crisis shelter services, twenty-four (24) hours a day, seven (7) days a week; and (3) develop and provide behavioral home settings for children and adults with challenging behaviors.

Such services shall not supplant or duplicate entitlements and services required by state or federal statutes.

C. Financial

Self-determination is another way of saying *freedom.* It is a fundamental human right. It means that people have *authority* over how their lives will be lived, where and with whom. It means that people have control over the resources needed for their *support*, as well as *responsibility* for their decisions and actions. (The Principles: 1997 copyright @ Ellen M. Cummings)

Individuals may have right to choose, but federal/state funding may not pay for their choice, or at least not at the level they are requesting. Limited financial resources have resulted in limited residential options for individuals. This is contrary to the principles of self-determination.

Historically, funding for residential services for persons with developmental disabilities has been inadequate. Collaborative partnerships between the state and the developmental disabilities community must be established to increase residential options and support individuals with developmental disabilities in their choice of residential settings.

1. Rate of Payment

Issues:

a. Adult foster home and developmental disabilities domiciliary home reimbursement rates are the same, however the number of individuals residing in each type of home is different. Up to two adults are allowed to live in an adult foster home and up to five (5) adults in a developmental disabilities domiciliary home. The rate currently paid is too low to cover even room and board much less personal care.

b. Semi-independent living rates are the same as independent living, except that for semi-independent living, the United States Department of Housing and Urban Development may pay for housing.

c. Equitable payment is an issue. There is inequity in reimbursement based on needs. Attempts to make it equitable in the past resulted in one level of payment. Agency agrees to payment for twenty-four (24) hour supervision and care including personal care as part of the contract. Increase in reimbursement for providers is needed as there hasn't been an increase since the 1980's. Service delivery methods have also changed as the method used focused on group services and now are very individualized.

d. Act 168, Session Laws of Hawaii 2005, provides a mechanism for the Department of Health to license developmental disabilities domiciliary homes and enter into

contracts for developmental disabilities domiciliary homes and apartment complexes for additional payments. However, availability of funds is subject to legislative appropriation.

2. Level of Care

Issues:

a. Current Level of Care payments for individuals residing in agency-operated developmental disabilities domiciliary homes are not adequate to meet the needs of the individual. Agency operated homes have higher costs associated with providing shift staff on board twenty-four (24) hours, seven (7) days per week, and providing employment related benefits such as medical insurance, worker's compensation, vacation and sick leave, and temporary disability insurance. Whereas family operated homes do not require a night shift to monitor and supervise during the "sleeping" hours since the family is already in the home and provision of employment benefits is not an issue.

b. Funding for twenty-four (24) hour care is inadequate and that the requirement to provide twenty-four (24) hour care should be removed from the licensing requirements. The issue is that not all individuals living in developmental disabilities domiciliary homes require twenty-four (24) hour care.

Recommendation:

a. Residential/custodial care needs to be defined clearly. Several options should be considered:
    i. Add the definition of twenty-four (24) hour, seven (7) day per week supervision or care to the rules for developmental disabilities domiciliary homes (Hawaii Administrative Rules Chapter 89-11-2), which falls under the purview of the Department of Health, Developmental Disabilities Division and Office of Health Care Assurance.
    ii. Amend the part of the definition in the rules that refers to the number of people who can live in the residence from "up to five (5)" to "three (3) to five (5)" individuals.
    iii. Define what "care" and "supervision" mean. It was noted that a definition of personal care is included in the rules to mean basic activities of daily living.
    iv. Amend the rules to delete individualized care, and add that services be provided in the group arena. Care needs to be provided on an individualized basis as individuals have differing needs.

3. Federal Reimbursements

Issues:

a. Federal reimbursements for home and community-based waiver services are only for services, not room and board costs.

b. Hawai‘i’s agreement between the Department of Human Services and the Social Security Administration enabled the State to receive Supplemental Security Income payments for individuals living in domiciliary settings. The Social Security Income payments of $521.90 in state funds and $603.00 (effective January 1, 2006, reflecting a cost of living increase of 4.1 percent) in federal funds for a total of $1124.90 per month are applied towards room and board only. The federal portion may increase yearly depending on the Cost of Living Allowance.

c. The Social Security Income payments are for only individuals living in domiciliary settings. Individuals living in independent arrangements only receive the Federal portion of $603.00 per month (effective January 1, 2006, reflecting a cost of living increase of 4.1 percent).

d. Social Security Income payments cannot be used as state-match for federal reimbursement for waiver services. Part of the agreement between the Social Security Administration and the Department of Human Services is that Hawai‘i must show “maintenance of effort” by meeting or exceeding the amount spent by the State each year. In essence, the state payment of $521.90 is the minimum the State must provide.

e. Most community-based residential services are funded through rental payments from residents, who use their income (as applicable) from Social Security Disability Income benefits, Social Security Income, and State Supplemental Payments.

   Prior to 1996, there were three (3) levels of payments that reflected an individual’s need. Current level of care payments has been integrated into one (1) payment because the majority of individuals were in the highest level of care.

Recommendation:

a. Consider an option to create levels for payments depending on need or have a capped amount for each individual. Levels of payment would be similar to personal assistance services with different levels/standards of care.

4. Liability/Risk Management

Issues:

a. The issue of liability limits individual choice.

b. There is a risk factor for care providers due to the responsibility. Licensure makes them responsible when they are required to provide care twenty-four (24) hours per day, seven (7) days per week. Liability coverage is not a requirement for adult residential care homes.

c. Comprehensive general liability insurance is required in the State's Medicaid waiver provider agreements for homeowners operating these businesses. Insurance is not required by Department of Health regulations.

d. Any contract with the State will require insurance coverage.

e. There are worker's compensation issues because of risk to health care workers.

f. What alternatives are available if a caregiver refuses to continue to provide services to the individual because of liability? There are situations where an individual who attempted suicide and is being evicted due to liability issues. In a situation where the person rents their own home, the Landlord/Tenant laws would prohibit these types of evictions. In this case, either insurance premiums are increased or the provider is dropped from the insurance policy. When an individual tries to commit suicide, the record of suicide follows the person or there is a "grapevine" effect, and it becomes difficult to place the person.

g. How do you balance dignity of risk with a regulatory setting? Dignity of risk means having opportunities to succeed or fail. For people with developmental disabilities, the opportunity and ability to take chances and make choices is at the heart of living self-determined lives. Everyday, one is faced with choices, and there is risk in every choice, positive or negative. No one enjoys to be managed by others. There is no dignity in depending on others to choose for the individual when the individual can make decisions on his/her own. People with developmental disabilities tend to be protected because of their disability. However, well-meaning intent results in denying them the right, freedom, and authority to experience everyday life experiences like other people without disabilities.

Current Initiatives:

a. Department of Health has determined a methodology for entering into contracts with providers of developmental disabilities domiciliary homes and apartment complexes.

b. The Developmental Disabilities Division is looking to revise the Home and Community Based Services Waiver for persons with developmental disabilities/mental retardation to incorporate a residential habilitation service to provide a per diem rate based on levels of individual needs. This is contingent on approval by the Centers on Medicare and Medicaid Services.

Recommendations:

a. Initiate and support legislative measures to provide continued funding for the implementation of Act 168/2005.

b. Determine the feasibility to provide payments for insurance for caregivers or provide reimbursement for insurance for caregivers.

c. Establish partnerships between the State and insurance companies to offer lower rate premiums to caregivers for persons with developmental disabilities.

D. General

1. Housing and Residential Options for Other Populations

The Community Housing Program developed in 1989 has continually developed through state and federal leveraging of funds an array of housing options for persons with severe and persistent mental illness based on "best practices" and individual needs o consumers. In 1998, the Adult Mental Health Division developed and implemented the Supported Housing Program. The program is administered through a purchase of service contract with Steadfast Housing Development Corporation. The goal of this program is move consumers off the Adult Mental Health Division funded "bridge subsidy" to Section 8.

The Supported Housing Program has two (2) components: The "Bridge" subsidy, which is a temporary subsidy provided to consumers in the program and the support provided by "residential specialist(s)". "The program allows eligible individuals to meet financial obligations to landlords under lease agreements. This includes security deposits, first month's rent, utility hookups, and reasonable rental shortfalls. Consumers in the program receive on-going and flexible mental health services from the Community Mental Health Center, through the Assertive Community Treatment, Intensive/Targeted Case Management teams and other housing support providers.

The Supported Housing Program "allows consumers to live in permanent type housing of their choice, assume responsibility of tenancy and provides them with services that will allow them to assume the role of tenant and neighbor. In supported housing the consumer selects housing from a variety of housing options that are affordable, decent, safe, owned and managed by community landlords or housing agencies. Consumers are required to pay maximum rent equal to one-third of their monthly income."
(Source: Department of Health, Adult Mental Health Division)

2. Co-Occurring Diagnoses

There is recognition that there is an increase in the population of individuals with co-occurring diagnoses (developmental disabilities and mental illness). Further review and assessment is needed on whether or not another waiver is needed to address the needs of this population. Both the Department of Health's Adult Mental Health Division and Developmental Disabilities Division are working collaboratively to provide services for individuals co-occurring diagnoses through collaboration with case managers from both divisions. A Memorandum of Agreement is being developed between the divisions.

3. Preferences and Choices

Hawai'i Revised Statutes Chapter 333F-2 requires the Department of Health, Developmental Disabilities Division to administer or may provide available supports and services based on a client-centered plan, which resulted from client choices and decision-making that allowed and respected client self-determination.

Hawai'i Revised Statutes Chapter 333F-8 establishes rights of persons with developmental disabilities. Refer to Section IV, page 41.

The Centers for Medicare and Medicaid Services require states to develop a quality assurance system based on a quality assurance framework. The framework includes seven (7) focus areas. One of the focus areas is Participant Rights and Responsibilities with the desired outcome that "Participants receive support to exercise their rights and in accepting personal responsibilities."

The landmark U.S. Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999) ruled that under the American with Disabilities Act, a person with a mental disability is qualified to live in the community when the state's treatment professionals have determined that community placement is appropriate, the individual is not opposed to transfer from an institution to a less restrictive setting, and the placement can be reasonably accommodated within available state resources. States were required to develop a comprehensive, effective working plan that addresses placing qualified persons with mental disabilities in less restrictive settings.

Hawai'i's Olmstead Plan was submitted in October 2002 to then Governor Benjamin Cayetano. An Implementation Plan was completed and submitted to Governor Linda Lingle for her approval in January 2005. The Plan addresses key areas that include strengthening financial resources and mechanisms, and supporting individuals to find an appropriate, affordable home of their choice to name a few.

<u>Issues:</u>

a. Individuals in current residential settings may be required to move to another home due to change in their condition, status of home and or caregiver's licensure/certification, change in program requirements, etc. An individual should

not be displaced due to factors beyond their control. What needs to be done to allow individuals to remain in their current living arrangements?

b. Current residential settings may be available, but not affordable, not an ideal or appropriated setting of what an individual may want or would benefit from.

c. People with disabilities have a right to take risk.

d. What is the difference between two (2) individuals living in an adult foster home and two (2) individuals who choose to live together other than the adult foster home requires a license?

e. There is a lack of capacity in the community for housing when needing to provide placement for individuals who are being relocated from one residence to another. There isn't an adequate pool of housing resources or adequate residential settings available that meet state licensure requirements for adult foster homes, developmental disabilities domiciliary homes, and adult residential care homes. Consequently, an individual may be placed in a residential setting that is not licensed due to unavailable licensed settings or inappropriate residential settings.

f. Individual's choice on residential option and whom they live with is based on what the individual expresses for support in whatever housing option they choose.

E. Licensure/Regulations

Issues:

a. Currently, if an individual chooses to live in a congregate group setting, he/she may have to live in a licensed setting according to State licensure standards and requirements.

b. Licensing involves City and County Building Code requirements, the Department of Human Services requirements for individuals receiving Medicaid waiver services, and the Department of Health, Office of Health Care Assurance licensing requirements for caregivers.

c. What is an ideal number of individuals to live in a home, three (3), four (4), and five (5) without the home having to be licensed?

d. Numerous discussions have taken place over how many individuals can live in a home without needing to be licensed. Current administrative rules allow not more than five (5) individuals with developmental disabilities in a developmental disabilities domiciliary home and up to two (2) adults with developmental disabilities in an adult foster home.

e. There were varying opinions about the number of individuals living in a setting and what number needed to be licensed. For those with challenging behaviors, a home with five (5) individuals with similar behavioral needs may not be appropriate or beneficial to the individuals as well as the caregiver.

f. County codes require a license for five (5) individuals. Four (4) individuals in living in one (1) setting would depend on the setting. It is not always the number of individuals living in a setting, but also the individual's needs and provision of services that the individuals require.

g. Residential Settings options have to do with funding/economic issues – cost of living and liability issues.

h. Safety is being addressed by case managers and through the Medicaid waiver.

i. Providers are required to meet licensure requirements without reimbursement or with low reimbursement rates. Worker's compensation, insurance, and facilities costs are not reimbursed. Social Security Income and State Supplemental Payment reimbursement is not enough to support residential living costs in Hawai'i. This is cost prohibitive for providers.

j. Who has the authority to determine what the ideal number is?

k. Current State statutes and administrative rules for adult foster homes, adult residential care homes, and developmental disabilities domiciliary homes regulate the number of individuals allowed to live in each type of setting.

l. Who is to say that individuals who want to and express the desire to live together can live together?

m. Individuals have the right to choose where they want to live with the necessary supports and not be limited to live only in a licensed setting. This is a civil rights issue and is addressed in Hawai'i Revised Statutes Chapter 321-15.6 (f). This relates only to care homes.

1. Settings that Require Licensure vs. Settings that Do Not Require Licensure

Issues:

Settings that Require Licensure:

a. Increase number of staff needed to meet regulations.

b. Increase cost for staff hire.

c. Overtime pay for staff.

d. Liability insurance fee.

e. Need for continuous training to meet requirements.

f. Regulations are costly and cost prohibitive.

g. Does not guarantee health, safety, and welfare.

h. There are funds to support agencies in getting their license and meeting regulations.

Settings that Do Not Require Licensure

a. Receive Medicaid reimbursements that may be higher than the established domiciliary payments.

b. Decreased number of staff needed to hire.

c. Decreased cost for staff hire.

Where is the fine line between licensed vs. not licensed? If a case manager does the assessment of an individual and the individual can be sustained by primary services and the circle of support, then the services should be with the individual not with the setting/facility. The individual should be able to live in the setting of their choice whether it is licensed or not licensed. Why does the setting itself have to be licensed if the care-giving is already regulated? Who determines who needs to be licensed?

The debate of licensed vs. not licensed remains an issue. Focus is on the overall physical, psychological, social, and emotional well being of the person.

2. Settings That Do Not Require A License

The Task Force agreed that the following settings do not require licensure:

a. Person lives with family (parent, sibling, cousins, aunt/uncle, etc.).

b. Person lives in a family-owned home with a live-in caregiver who is paid.

c. Person lives in a home that he/she rents from landlord with no paid supports. In this situation the landlord has no interest other than renting the home to the individual.

d. Person lives in a home that he/she rents from the landlord and receives paid support from someone coming into the home.

In situations where individuals live in a community setting that is not licensed or certified, Medicaid supports would be contingent upon something else being there to ensure health and safety. The Department of Human Services, as the State Medicaid agency, needs to have some assurance that there is a mechanism, if not licensing or certification, to assure health and safety of the individual via a face-to-face visit in the setting, possibly by a case manager.

In situations where the only Medicaid waiver services person is getting are outside of the home (e.g., adult day health services and no personal assistant comes into the home), the individual is fully able to make decisions, and happens to be living in a home that he/she rents from someone else. There needs to be assurance that there is a mechanism to assure the health and safety of the individual via a face-to-face visit in the setting.

e. Person lives in the home of another and does not receive paid Medicaid waiver supports in the home.

f. When one (1) or two (2) individuals rent a single apartment unit from a landlord where rent is not paid by the Medicaid waiver. The maximum number of individuals to live in a single apartment unit is two (2) and rent is not paid through the Medicaid waiver**.**

3. Health and Safety

Issues:

a. What factors guarantee health and safety?
There was consensus that there is no guarantee (100%) for assuring health and safety. There are differing perceptions on what health and safety means. What could be considered a health and safety issue may not be the same for another. Factors can be in place to a maximize health and safety outcomes for people residing in various settings. Once a year monitoring by a licensing agency for re-certification and licensure does not necessarily assure health and safety. This may be one aspect of assuring health and safety along with other factors such as ongoing monitoring by the individual's caregiver, case manager, and service provider.

There needs to be a workable definition of achievable health and safety and the factors that meet that criterion.

b. Licensure is not required by Centers for Medicaid and Medicare Services, quality assurance is. The Centers for Medicaid and Medicare Services gives states flexibility on how they are going assure health and welfare. It is not dictated as to what states are required to do to protect the health and welfare other than to assure that there are necessary safeguards in place. What are considered reasonable assurances?

The Code of Federal Regulations, Sub Part G-Home and Community-Based Services: Waiver Requirements, State Assurances (42 C.F.R. § 441.302) requires states to provide satisfactory assurances. In the area of health and welfare, it states, "Assurance that necessary safeguards have been taken to protect the health and welfare of the residents of the services. Those safeguards must include:

i. Adequate standards for all types of providers that provide services under the waiver;
ii. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and
iii. Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 C.F.R. Part 1397 for board and care facilities."

(Source: National Archives and Records Administration, Code of Federal Regulations on the Government Printing Office Access site at: www.access.gpo.gov/nara/cfrl)

c. What is the purpose of licensing a home?
To assure resident health and safety, by requirement of minimum standards that should be met in order that the structure is safe, the provider(s) is minimally competent to meet the needs of the resident, and a minimum standard of care is established.

d. At what point does a license become necessary (level of care, number of people, etc.)? Several scenarios were presented to discuss this issue:

i. Scenario 1
An individual lives in an apartment and has a rental agreement. The City and County housing agency monitors the home because of the United States Department of Housing and Urban Development Section 8 certificate and they inspect the home annually. The individual's Department of Health case manager has completed an assessment and the individual and his/her circle of support determine that he/she can be sustained in the apartment with primary waiver services. The case manager provides periodic monitoring according to the Individualized Service Plan. Because the person receives waiver services and the Department of Human Services is the State Medicaid agency, they also monitor the individual and the apartment to assure Medicaid requirements are met.

ii. Scenario 2
A home is operated by an agency. The individual's case manager looks at the home and determines the home to be adequate to meet the needs of the individual. The individual is placed in the home with a rental agreement, food stamps, and twenty-four (24) hour supervision is provided. There are a total of three individuals living in the home.

iii. Scenario 3
Two (2) individuals want to live together and rent an apartment. A rental agreement would be between the two (2) individuals and the landlord. Necessary waiver services and supports will be provided. Would the apartment and/or landlord need to be licensed? How is the home monitored?

Part of the case manager's responsibility is to monitor the health and welfare of the individual. A report can be made to the Department of Human Services, Adult Protective Services if there is suspicion of abuse/neglect. More controls can be placed on the services. An adult has the right to refuse Adult Protective Services involvement unless diminished capacity is determined. The State has limited regulatory control in private homes. There is greater control in a licensed setting.

e. When the State is providing funds to pay for individual services and contracts with private providers, the State needs to have assurances from the providers that health and safety requirements are met.

f. There needs to be flexibility established within the system. No need for multiple source of monitoring to assure health and safety.

g. Need to determine/identify the balance between and health and safety with freedom of choice.

h. Should a special waiver be considered for this population?

i. Need to look for alternate means to provide safety and civil rights to individuals with developmental disabilities.

j. How can an individual health and safety by assured in any given setting?

k. What is the minimal accepted health and safety?

l. What is minimal expectation that we can live with?

m. What can we do to achieve that outcome?

n. How do we protect and also allow freedom?

IV. IDENTIFY STATUTES, ADMINISTRATIVE RULES, POLICIES, AND DIRECTIVES THAT IF REVISED WOULD ALLOW SETTINGS THAT DO NOT REQUIRE LICENSURE, HOWEVER WOULD BE ABLE TO PROVIDE SAFE AND HEALTHY ENVIRONMENTS AS A RESIDENTIAL OPTION

The initial report (Senate Concurrent Resolution 79 Senate Draft1 House Draft 1, 2004) included statutes, administrative rules, policies and directives applicable to residential settings for persons with developmental disabilities. The Task Force has included the information again in this report.

The following is a review and description of the statutes, administrative rules, policies and directives that govern adult residential care homes, adult foster homes and developmental disabilities domiciliary care homes for individuals with developmental disabilities. The description includes only pertinent sections that apply to residential settings for persons with developmental disabilities.

1. Code of Federal Regulations, Subpart G, Home and Community-Based Services: Waiver Requirements, State Assurances (42 C.F.R. § 441.302)

Unless the Medicaid agency provides the following satisfactory assurances to the Centers for Medicaid and Medicare Services, the Centers of Medicaid and Medicare Services will not grant a waiver under this subpart and may terminate a waiver already granted:

> (a) *Health and Welfare* - Assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include-
> (1) Adequate standards for all types of providers that provide services under the waiver;
> (2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and
> (3) Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 C.F.R Part 1397 for board and care facilities.[1]

[1] Code of Federal Regulations, Subpart G, Home and Community-Based Services: Waiver Requirements, State assurances (42 C.F.R. § 441.302)

2. Americans with Disabilities Act Title II, Public Services, Subtitle A: Prohibition Against Discrimination and Other Generally Applicable Provisions

According to the Americans with Disabilities Act of 1990 Section 202, discrimination is defined as, "Subject to the provisions of this title, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."

3. United States Supreme Court decision in *Olmstead v. L.C.,* 527 U.S. 581 (1999)

What did the Court say about Integration?

a. Institutional placement of persons who can handle and benefit from community settings perpetuate unwanted assumptions that persons so isolated are incapable or unworthy of participating in community life.
b. Confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.
c. Olmstead affirmed the American with Disabilities Act integration mandate:
    i. The Americans with Disabilities Act's anti-discrimination provisions prohibit state from placing a person in an inappropriate institutional placement.
    ii. Requires states to make reasonable modifications to its existing programs to avoid inappropriate institutionalization.
    iii. To accommodate community placement, a state needs to make reasonable accommodations, but does not need to make fundamental alterations on the services or programs.

4. Chapter 333F, Hawai'i Revised Statutes, 2003 Cumulative Supplement, Services for Persons with Developmental Disabilities or Mental Retardation

Section 333F-1: Definitions

Individualized Service Plan: means the written plan required by section 333F-6 that is developed by the individual with the input of family, friends, and other persons identified by the individual as being important to the planning process. The plan shall be a written description of what is important to the person, how any issue of health or safety shall be addressed, and what needs to happen to support the person in the person's desired life.[2]

[2] Chapter 333F, Section 333F-1, Hawai'i Revised Statutes, 2003 Cumulative Supplement

Section 333F-2: Developmental disabilities system

"(a)....The department shall administer or may provide available supports and services based on a client-centered plan, which resulted from client choices and decision-making that allowed and respected client self-determination…"[3]

Section 333F-7: Provision of services

The department shall:
(1) Assist the individual to develop, with the help of family and friends, if necessary, an individualized service plan;
(2) Identify the amount of dollars available to the individual to effectuate the individualized service plan; and
(3) Allow consumers to direct the expenditures of the identified funds.[4]

Section 333F-8: Rights of persons with developmental disabilities or mental retardation

(a) Persons with developmental disabilities shall have the following rights:
(1) To receive the least restrictive, individually appropriate services, including a program of activities outside the residence in accordance with the person's individualized service plan;
(2) To reside in the least restrictive, individually appropriate residential alternative located as close as possible to the person's home community within the State;
(3) To the extent it is individually appropriate as decided after due consideration afforded the preferences of the person with developmental disabilities or mental retardation, to:
    (A) Interact with persons without disabilities in a non-treatment, non-service-oriented setting;
    (B) Live with, or in close proximity to, persons without disabilities; and
    (C) Live in a setting which closely approximates those conditions available to persons without disabilities of the same age;
(4) To reasonable access to review medical, service, and treatment files and to be informed of diagnoses;
(5) To develop a plan with the input of family and friends that identifies the supports needed to accomplish the plan rather than purchase a program;
(6) To control, with the help of family and friends as necessary, an identified amount of dollars to accomplish the plan;
(7) To direct the provision of resources, both paid and unpaid, that will assist an individual with a disability to live a life in the community rich in community association and contribution;
(8) To a valued role in the community through employment, participation in community activities, volunteering, including being accountable for spending public dollars in ways that are life enhancing; and
(9) To privacy and confidentiality, to the extent possible, in connection with services provided to the person.

[3] Chapter 333F, Section 333F-2, Hawai'i Revised Statutes, 2003 Cumulative Supplement
[4] Chapter 333F, Section 333F-7, Hawai'i Revised Statutes, 2003 Cumulative Supplement

(b) Rights listed in this chapter shall not be construed to replace or limit any other rights, benefits, or privileges, including other statutory and regulatory due process rights and protections, to which a person with a developmental disability or mental retardation may be entitled.
(c) The enumeration or granting of these rights does not guarantee the provision of services.[5]

5. Chapter 321, Department of Health, Hawai‘i Revised Statutes, 2003 Cumulative Supplement

Section 321-11: Subjects of health rules, generally

The department pursuant to chapter 91 may adopt rules that it deems necessary for the public health and safety respecting:

…(10) Hospitals, freestanding surgical outpatient facilities, skilled nursing facilities, intermediate care facilities, adult residential care homes, adult foster homes, assisted living facilities, special treatment facilities and programs, home health agencies, hospices, freestanding birthing facilities, adult day health centers, independent group residences, and therapeutic living programs, but excluding youth shelter facilities unless clinical treatment of mental, emotional, or physical disease or handicap is a part of the routine program or constitutes the main purpose of the facility, as defined in Section 346-16 under “child care institution”. For the purpose of this paragraph, “adult foster home” has the same meaning as provided in Section 321-11.2;

(11) Hotels, rooming houses, lodging houses, apartment houses, tenements, and residences for persons with developmental disabilities including, but not limited to those built under federal funding...

The department may require any certificates, permits, or licenses that it may deem necessary to adequately regulate the conditions or businesses referred to in this section.[6]

Section 321-11.2: Adult Foster Homes

Section 321-15.6: Adult residential care homes; licensing.

Section 321-15.62: Expanded adult residential care homes; licensing.

Section 321-15.9: Developmental disabilities domiciliary homes.

[5] Chapter 333F, Section 333F-8, Hawai‘i Revised Statutes, 2003 Cumulative Supplement
[6] Chapter 321, Section 321-11, Hawai‘i Revised Statutes, 2003 Cumulative Supplement

6. Hawai‘i Administrative Rules, Title 11, Department of Health, Chapter 89, Developmental Disabilities Domiciliary Homes

7. Hawai‘i Administrative Rules, Title 11, Department of Health, Chapter 148, Certification of Adult Foster Homes

8. Hawai‘i Administrative Rules, Title 11, Department of Health, Chapter 100, Adult Residential Care Homes

V. IDENTIFY STATUTES, ADMINISTRATIVE RULES, POLICIES, AND DIRECTIVES THAT NEED TO BE REVISED TO REFLECT INDIVIDUAL CHOICE AND ASSURE CIVIL RIGHTS, HEALTH AND SAFETY

The following statutes and administrative rules were identified to be reviewed to determine what revisions are needed to support and reflect individual choice and assure civil rights, health and safety.

1. Adult Foster Homes
Chapter 321, Section 321-11.2, Hawai‘i Revised Statutes,
Title 11, Department of Health, Chapter 148, Hawai‘i Administrative Rules,

2. Adult Residential Care Homes
Chapter 321-15.1, Hawai‘i Revised Statutes
Title 11, Department of Health, Chapter 100, Hawai‘i Administrative Rules

Licensing
Chapter 321, Section 321-15.6, Hawai‘i Revised Statutes

Expanded Admissions
Chapter 321, Section 321-15.61, Hawai‘i Revised Statutes

Expanded Licensing
Chapter 321, Section 321-15.62, Hawai‘i Revised Statutes

3. Developmental Disabilities Domiciliary Homes
Chapter 321, Section 321-15.9, Hawai‘i Revised Statutes,
Title 11, Department of Health, Chapter 89, Hawai‘i Administrative Rules

4. Services for Persons with Developmental Disabilities or Mental Retardation
Chapter 333F, Hawai‘i Revised Statutes

VI. COORDINATE ACTVITIES WITH THE OLMSTEAD TASK FORCE TO PREVENT DUPLICATION OF WORK

The Olmstead Task Force submitted its recommended Olmstead Implementation Plan (Plan) to Governor Lingle in January 2005. Department Directors were given copies of the Plan and were asked to review and provide feedback to her Policy Office. Review and comments were completed and forwarded from the Policy Office to the Department of Human Services.

Included in the Plan was an Objective that was coordinated with the Residential Settings Task Force. Objective 3b in the Plan stated, "Change polices for existing resources to increase flexibility in how funds are used and give authorization to people with disabilities to control how they use their own funds." The following two strategies were identified for this objective that involved work with the Residential Settings Task Force:

1. Strategy 3b2: Review state regulations so that people with disabilities, their families and caregivers can decide how their individual benefits will be used for the home and services of their choice.
2. Strategy 3b3: Identify policies that create disincentives to independent community living and consumer choice by establishing a mechanism for people with disabilities, their families and caregivers to provide feedback.

Once the Governor approves the Plan, the Olmstead Task Force will have to reconvene to address next steps. The Task Force will coordinate its activities to address the above strategies with the Residential Settings Task Force.

VII. UPDATE OF RECOMMENDATIONS FROM THE INITIAL REPORT (SENATE CONCURRENT RESOLUTION 79 SENATE DRAFT 1 HOUSE DRAFT 1)

The following recommendations were included in the initial report and were not considered inclusive of all recommendations considered and discussed by the Task Force. An update is provided for each of the recommendations.

1. Amend Chapter 321, Hawai‘i Revised Statutes, Developmental Disabilities Domiciliary Homes

a. To amend Section 321-15.9 (f) to authorize the Department of Health to determine the rate of payment for residents in developmental disabilities domiciliary homes. The amendment would allow Department of Health to determine appropriate rate of payment that addresses individual needs and choice. Additional funds will be required from the Legislature.

The rate of payment would be in addition to the current State Supplemental Payment of $521.90 for individuals residing in domiciliary care.

The language to amend Section 321-15.9 (f) would be as follows:
“The rate of payment for residents in the developmental disabilities domiciliary homes shall be determined [on the same basis as domiciliary care homes as provided under section 346-53.] by the department of health.” Statutory material to be repealed is bracketed. New material underscored.

b. To amend Section 321-15.9 (c)(3): “Provide for plans of care which include community integration and [training] support of persons residing in the licensed homes.” Statutory material to be repealed is bracketed. New material underscored.

The language for training individuals is outdated and was included in past contracts for providers of group homes. Focus on individualized service plans, plans of care, etc., is to support the individual to live in the community.

STATUS: A bill was introduced based on this recommendation. Initial legislation was incorporated in Senate Bill 3, passed by the Legislature and signed into law by the Governor as Act 168/05. The rate of payment issue, raised as part of this recommendation, was addressed in Senate Bill 1620, Section 14 that included an appropriation of $485,000 for Fiscal Year 2005-2006 to carry out the activities included in Senate Bill 3.

2. Amend Section 333F-2, Hawai‘i Revised Statutes

Amend Section 333F-2, “(c)(9) Provision of community residential alternatives for persons with developmental disabilities or mental retardation, including group homes and

homes meeting intermediate care facility for individuals with mental retardation standards" by amending the above language to state, "Provision of community residential alternatives for persons with developmental disabilities or mental retardation, including [group homes and] homes meeting intermediate care facility for individuals with mental retardation standards, and in a setting of his/her choice if the individual/circle of support determines that the individual can be sustained with supports, and the supports are attached to the person;" Statutory material to be repealed is bracketed. New material underscored.

STATUS: Senate and House bills were introduced and passed by the respective subject matter committees; however, neither was successful in being heard by the Senate Ways and Means and House Finance committees. This is a priority for the Task Force.

3. Department of Health, Developmental Disabilities Division, in collaboration with the Residential Settings Task Force, to revise applicable Hawai'i Revised Statutes and Hawai'i Administrative Rules regarding residential settings to reflect the principles of self-determination and individual choice.

This initiative will require at least one (1) year completing and could be accomplished during the interim period between the 2005 and 2006 legislative session.

STATUS: The Task Force recognizes this as a priority activity and is being currently addressed.

4. Department of Health, Developmental Disabilities Division to pursue Supported Housing/Bridge Subsidy Program as a residential option through a pilot project.

The Department of Health, Adult Mental Health Division's Supported Housing/Bridge Subsidy Program has demonstrated success in allowing individuals with mental illness to live independently in housing of their choice. This model is a practical and realistic approach to increasing residential options for individuals with developmental disabilities. The pilot project would include a small number of individuals currently served by the Developmental Disabilities Division. The project would require funds in addition to Developmental Disabilities Division's existing budget from the Legislature.

STATUS: Funds for the above were included in the appropriation for Senate Bill 3, however, it was not funded.

5. Department of Health, Developmental Disabilities Division to establish a Housing Specialist within Developmental Disabilities Division.

A Housing Specialist shall have the responsibility to develop a comprehensive housing plan and implement the Supported Housing/Bridge Subsidy Program including coordinating with the Housing and Community Development Corporation, United States Department of Housing and Urban Development, and other housing agencies to pursue

other housing alternatives. This position would be located in the Developmental Disabilities Division. The authorization and appropriation for this position will be required by the Legislature.

STATUS: A Housing Specialist position is in the process of being created within the Developmental Disabilities Division.

6. Department of Health, Developmental Disabilities Division to initiate discussion with Ann O'Hara from Technical Assistance Collaborative, Inc., for information and technical assistance regarding housing options and projects.

Ms. O'Hara served as a consultant to the Department of Health, Adult Mental Health Division, in its implementation of the Supported Housing/Bridge Subsidy Program. She would be a great resource for Developmental Disabilities Division in providing technical assistance for the implementation of the Supportive Housing/Bridge Subsidy project and other housing options for individuals with developmental disabilities.

STATUS: There has been no discussion with Ann O'Hara. Developmental Disabilities Division is willing to discuss the development of a comprehensive housing plan with Ms. O'Hara. The responsibility for the development of the comprehensive housing plan can be placed in the position that is being created. Developmental Disabilities Division could use technical assistance as needed. A technical assistance meeting with Ann O'Hara is pending and dependent on availability of funding for this consultant's services.

7. Department of Health, Developmental Disabilities Division to develop a comprehensive housing plan for individuals with developmental disabilities.

The plan should clearly identify specific action steps to address residential alternatives. Refer to Recommendation 5.

STATUS: The housing specialist and technical assistance with Ms. O'Hara will help the Developmental Disabilities Division to develop a comprehensive housing plan.

8. Department of Health, Developmental Disabilities Division to consider the following strategies in determining the rate of payment:

a. Contracts for funding for agency-operated developmental disabilities domiciliary homes.

b. A cost reimbursement and differential for shift staff.

c. A higher rate to providers with a "no reject policy" for shift staff.

d. Agency contracts that are based per program not based on the individual.

e. Calculate for "vacant" days for individuals. This would be for unanticipated absences of the individual.

Note: Medicaid Home and Community-Based Services waiver funds cannot be used to reimburse for vacant days.

STATUS: Developmental Disabilities Division plans to use Senate Bill 1620 rainy day fund monies to implement Senate Bill 3. However, the funds to be received by the Developmental Disabilities Division are not in the full amount and are only for fiscal year 2005-2006. Assistance is needed from task force to pursue continued funding for this area.

9. Amend Chapter 89, Hawai'i Administrative Rules for Developmental Disabilities Domiciliary Homes.

Any amendments to Chapter 89, Hawai'i Administrative Rules will reflect amendments made to Chapter 321. Refer to Recommendation 1.

STATUS: The above is pending any recommendations from the Task Force.

VIII. RECOMMENDATIONS

The following recommendations were based on the Task Force's review and discussions of statutes, administrative rules, policies, current practices, issues relating to residential settings and options for people with developmental disabilities, and the status of recommendations made in the initial report for Senate Concurrent Resolution 79 Senate Draft House Draft 1. The recommendations were based on the majority of the Task Force and may not be considered as having full support of all individual members.

The recommendations below are considered overarching recommendations that cut across the five (5) priority areas identified and discussed in Section III.

1. Support funding for Department of Health, Developmental Disabilities Division to implement Act 168/2005.

2. Support Department of Health, Developmental Disabilities Division's emergency appropriation request for developmental disabilities services.

3. Continue to support the recommendation (# 2) included in the Senate Concurrent Resolution 79 Senate Draft 1 House Draft 1 initial report to amend Chapter 333F-2, Hawai‘i Revised Statutes, to include language relating to an individual's choice of residential setting. Refer to Pages 46-47.

4. Continue to support the recommendation (#3) included in the Senate Concurrent Resolution 79 Senate Draft 1 House Draft 1 initial report to revise applicable Hawai‘i Revised Statutes and Hawai‘i Administrative Rules regarding residential settings to reflect the principles of self-determination and individual choice. Refer to Page 47.

5. Continue to support the recommendation (#4) included in the Senate Concurrent Resolution 79 Senate Draft 1 House Draft 1 initial report to pursue a Supported Housing/Bridge Subsidy program as a community housing option through a pilot project. Refer to Page 47.

6. Initiate and support a legislative measure for the Department of Health to obtain a national consultant organization to assist in the implementation of the Task Force's recommendations.

7. Initiate and support a legislative measure to include the settings that do not require licensure (Pages 35-36, a. thru f.) in State statute.

8. Continue to convene the Residential Settings Task Force for one (1) year to address the five (5) priority areas identified an assist the Department of Health to implement the recommendations in the House Concurrent Resolution 40 House Draft 1 report submitted to the 2006 Legislature.

APPENDIX A

House Concurrent Resolution 40 House Draft 1

HOUSE OF REPRESENTATIVES

TWENTY-THIRD LEGISLATURE, 2005

STATE OF HAWAII

H.C.R. NO. 40 H.D. 1

HOUSE CONCURRENT RESOLUTION

REQUESTING THE HAWAII STATE COUNCIL ON DEVELOPMENTAL DISABILITIES TO CONTINUE to convene THE RESIDENTIAL SETTINGS TASK FORCE TO IDENTIFY ISSUES AND SOLUTIONS REGARDING INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES AND THEIR CHOICE OF RESIDENTIAL SETTING.

WHEREAS, the Twenty-second Legislature in 2004 adopted Senate Concurrent Resolution No. 79, S.D. 1, H.D. 1, requesting the Hawaii State Council on Developmental Disabilities (Council) to convene a task force to identify issues and solutions regarding individuals with developmental disabilities and their choice of residential setting; and

WHEREAS, the Council convened a residential setting task force and conducted meetings to address the concurrent resolution; and

WHEREAS, the task force completed an initial report describing the residential options currently available for

individuals with developmental disabilities and the statutes, administrative rules, policies, and directives that impact residential settings for those individuals; and

WHEREAS, the task force made recommendations regarding the rate of payment, individual choice of residential setting, and principles of self-determination and recommended a pilot project on supported housing, housing, housing specialist and plan, and technical assistance on housing options; and

WHEREAS, while the task force identified significant issues that surround and impact individual choice and self-determination, and recognized the complexity of these issues, the task force was not able to complete all the analysis; and

WHEREAS, it was agreed that further analysis was necessary to fully address the scope of increasing residential options, including residency in unlicensed homes for individuals with developmental disabilities; and

WHEREAS, the task force agreed by majority vote of its members to continue its work, including further analysis of statutes, administrative rules, policies, and directives and to continue to discuss and outline the details of recommendations that were not included in the report; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twenty-third Legislature of the State of Hawaii, Regular Session of 2005, the Senate concurring, that the Council is requested to continue to convene the task force to complete its work in addressing Senate Concurrent Resolution No. 79, S.D. 1, H.D. 1; and

BE IT FURTHER RESOLVED that the task force is requested to submit a follow-up report, including any proposed legislation, to the Legislature no later than 20 days prior to the convening of the Regular Session of 2006; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Chair and the Executive Administrator of the Hawaii State Council on Developmental Disabilities, Director of Health, Director of Human Services, President of the Hawaii Disability Rights Center, and Director of the Office of the Public Guardian.

APPENDIX B

Summary of Adult Residential Settings For Persons with Developmental Disabilities

Type of Residence	HAR/HRS	License / Certification	Funding	Payment Amount Monthly		# of unit					Capacity					# pending applicants	Max # people per unit
						Oahu	Hawaii	Maui	Kauai	Total	Oahu	Hawaii	Maui	Kauai	Total		
Adult Foster Home	Chap. 148 HRS 321-11	DOH/DDD	Social Security Income (SSI) benefits for Medicaid eligible and State Supplemental Payment (SSP)	Fed	$603.00	353	7	12	12	384	501	11	23	21	556		2
				State	$521.90												
				Total	$1,124.90												
Adult Residential Care Home (ARCH)	Chap 100 (100.1 pending)	DOH / OHCA	SSI and SSP benefits for Medicaid eligible & private pay from $2,000-$6,000	Fed	$603.00	419	48	17	16	500	2262	211	92	73	2,638	NA	Type I: 5
	HRS 321-11		Same as above	State	$521.90												Type II: 6 or more
Expanded Care		DOH / OHCA / DHS contract	Same as above	Total	$1,124.90												Type I: 2 Type II: 20% of capacity
Assisted Living Facility (ALF)	Chap. 90	DOH / OHCA	$2,000 to $4,000 w/ add'l costs at an ala carte rate depending on types of services provided			7	1	1	1	10	870	220	144	100	1,334	NA	n/a
Developmental Disabilities Domiciliary Homes (DDDom)	Chap. 89 HRS 321-11	DOH / OHCA / DDD	SSI and SSP DOH Supplemental (Act 168) Amt. Unknown	Fed	$603.00	30	1	1		32	133	5	5		143	NA	5
				State	$521.90												
				Total	$1,124.90												
Intermediate Care Facilities for persons with mental retardation (ICF/MR)	Chap. 99 & Fed. Reg. 42CFR, 442, 483.400 - 483.480	DOH / OHCA	Medicaid rates	DHS + CMS	$8,070.15	14		4		18	67		24		91	0	Small: 8 or less Large: 9 or more
Residential Alternatives Community Care Program (RACC)	Medicaid Waiver regulations & requirements	DHS	SSI and SSP	Fed	$603.00	562	55	20	3	640	1124	110	40	6	1,280	NA	2
				State	$521.90												
				Total	$1,124.90												
Semi- Independent			Rent is maximum 30% of income, and Section 8 if avaiable, DOH Supplemental (Act 168)	State	Unknown	48				48	48				48		1
Therapeutic Living Program (TLP)	Chapter 98, HRS 321-11, STF regs. w/ waivers under Memorandum of Agreement w/ DDD (Proposed Chap. 92)	DOH / OHCA	SSI benefits w/ additional wrap around services	Fed	$603.00	9	2	2	2	15	60	12	23	12	107	NA	NA
Special Treatment Facilities (STF)	CH.98, HRF321.11	DOH /OHCA				30	4	4		38	577	49	75		701	NA	
Family			SSI benefits w/ additional wrap around services	Fed	$603.00												
Independent			SSI and Private pay or Section 8 allowable	Fed	$603.00					NA					NA		
					TOTALS	1472	118	61	34	1685	5642	618	426	212	6898	0	10

APPENDIX B

Summary of Adult Residential Settings For Persons with Developmental Disabilities

Current Residents					Persons Eligible	Services	Comments
Oahu	Hawaii	Maui	Kauai	Total			
435	11	18	14	478	DD & unrelated to family	24 hr. care & training. Emphasis on creating home environment	
152	12	1	9	174	Unrelated to family, does not need ICF & requires minimal assist w/ ADL[1], does not need skilled or professional personnel on long term basis.	24 hr. living accommodations, minimal assist w/ ADL	Activities of Daily Living including personal care, shelter, protection, supervision, assistance, guidance or training, planned activities, food services, recognition of & provision for changes in health status, & arrangement for & transportation to medical & dental offices.
5			3	8	Persons requiring an ↑ level of care may remain in an ARCH until transfer if the operator is deemed capable by the DOH		
62	1	4	1	68	Individuals @ nursing facility (NF) level of care in an established ARCH.	24hr. living accommodations	
7				7		Meals, 24 hour staff available, individualized services to achieve greatest capacity to live independently	Facility shall be designed to maximized independence & self-esteem of limited mobility persons who feel they are no longer able to live on their own
113	5	4		122	MR or DD per HRS 333F	24 hr. care & supervision excluding licensed nursing care	
67		24		91	DD, unrelated to caregiver, resides in a dom home for a fee, unable to live independently, requires supervision, care & training, & does not require care by a licensed nurse, excludes individuals predominantly confined to a bed	Individualized active treatment prg.; providing health, social & rehabilitative services	
864	59	21	3	947	Individuals at the Skilled Nursing Level or ICF level of care that meet certain financial eligibility standards and can be cared for safely in a foster family home.	Adult Foster Care and case management in a community setting that meets their medical, ADL and IADL needs.	
48				48			
				0	Individuals or families who do not need the structure of a STF & are transitioning from a more restrictive setting to independent living	Mental health or substance abuse services	
				0			
1405	310	165	133	2013			
87	38	12	17	154			
3245	436	249	180	4110			

APPENDIX C

Summary of Adult Licensed Residential Settings and Community Housing for Persons with Mental Illness November 2005

Service	License or Certification	Funding Type –Agency	$ Amount-Daily Bed rate	Bed Capacity (in accordance to county zoning requirements)				
				O'ahu	Maui	Hawai'i	Kaua'i	Moloka'i
Specialized Residential (Dual)	STF-DOH-Licensed	Unit Rate-AMHD	$320.00	75	6	0	0	0
Specialized Residential	STF-DOH Licensed	Unit Rate-AMHD	$236.14	37	0	0	0	0
Specialized Residential (Interim Housing)	STF-DOH Licensed	Unit Rate-AMHD	$160.00	14	0	8	0	0
24-Hour Group Home	Certification-AMHD Licensed	Unit Rate-AMHD	$ 86.00	150	16	54	10	0
8-16 Hour Group Home	Certification-AMHD Licensed	Unit Rate-AMHD	$ 46.00	116	11	12	9	0
Semi-Independent Group Home	Certification-AMHD Licensed	Cost Reimbursement-AMHD + HUD awards	$ 36.00	125	16	30	14	0
Supported Housing Program: Bridge Subsidy	Certification-AMHD Licensed	Cost Reimbursement-AMHD	Bridge-$5000 annually per consumer	185	45	70	27	5
Supported Housing Program: Housing Support Team	Certification-AMHD Licensed	Cost Reimbursement-AMHD	$33,000 + fringe per Specialist	13	3	3	1	0
(4)-Shelter Plus Care Programs (rental subsidies)	Certification-AMHD Licensed	HUD awards + AMHD service match	Office of Social Ministry $629,160; and Steadfast Housing & Community Development-$2,727,336	70	17	32	0	0

APPENDIX D

List of Residential Settings Task Force Members

The Task Force included representatives from the following agencies, organizations, or affiliations mentioned in House Concurrent Resolution 40 House Draft 1:

1. Waynette Cabral, State Council on Developmental Disabilities
2. Espe Cadavona, Support Services Provider
3. Moira Chin, Office of the Public Guardian
4. Ellen Ching, Support Services Provider
5. Louis Erteschik, Hawaii Disability Rights Center
6. Maria Etrata, Operators of Adult Residential Care homes and Adult Foster homes
7. Dave Fray, Department of Health, Developmental Disabilities Division
8. Liz Ann Ihu, Family member of an individual with developmental disabilities
9. Patty Johnson, Department of Human Services, Social Services Division
10. Steve Kula, Residential Services Provider (Developmental Disabilities Domiciliary Homes)
11. Cathy Lowder, Office of the Public Guardian
12. Haaheo Mansfield, Family member of an individual with developmental disabilities
13. Deborah Miyasaka-Gushiken, State Council on Developmental Disabilities
14. Dianne Okumura, Department of Health, Office of Health Care Assurance
15. Irene Park, Department of Human Services, Social Services Division
16. Deborah Rivers, Individual with developmental disabilities
17. Millie Rogers, Individual with developmental disabilities
18. Michael Tamanaha, Department of Health, Developmental Disabilities Division
19. Garrett Toguchi, Family member of an individual with developmental disabilities
20. Barbara Yoshioka, Department of Health, Office of Health Care Assurance
21. Kathy Yoshitomi, Department of Health, Adult Mental Health Division